STATEMENT BY
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Chairman Davis, Congressman Waxman and Members of the Committee, I am Lieutenant General Franklin L. Hagenbeck, the Army's Deputy Chief of Staff for Personnel. Thank you for the opportunity to appear before your Committee today to discuss the Wounded Army Guard and Reserve Forces: Increasing the Capacity to Care.

Soldiers remain the centerpiece of our Army. It is the Soldier — fierce, well-trained, well-equipped and well-led — who serves as the ultimate expression of the capabilities the Army provides to the Joint Force and to the Nation. As always, we remain dedicated to the well being of our Soldiers and their families.

The Global War On Terrorism (GWOT) has triggered the largest mobilization of the Reserve Component (RC) since World War II. The exemplary performance of our Guard and Reserve Soldiers along side of their active component counterparts continues to demonstrate that we are indeed one Army…an Army whose components are practically indistinguishable from one another. I can assure you from firsthand experience that the Nation is completely justified in its pride of the performance of our Guard and Reserve soldiers in overseas contingency operations as well as here at home.

These soldiers deserve our continued commitment to training them to do their jobs and taking care of them and their families throughout their association with our Army. This includes providing the best care available to Soldiers who become injured or ill in the line of duty while serving our Country. Though this effort has not been without challenge, we continue

to improve our processes and strive to deliver compassionate and timely care to the Medical Holdover Soldier (MHO).

With Soldiers reporting to mobilization stations and returning from the theater through the evacuation chain or to demobilize, the Medical Holdover population quickly grew. In the midst of supporting the war fight, we realized that existing MHO policy and infrastructure were inadequate and immediately embarked on a series of corrective actions.

As the Deputy Chief of Staff (DCS), G-1, I am the proponent for the Active Duty Medical Extension (ADME) program and am responsible for the implementation guidance, execution of policy, and program management. The Medical Retention Processing (MRP) program is an Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)) policy. The G-1 is responsible for implementation guidance and execution of the policy. The Medical Retention Processing 2 (MRP2) program is an ASA(M&RA) program that is still being staffed for approval. The G-1 will be responsible for implementation guidance and execution of the policy once the program is approved.

The Active Duty Medical Extension (ADME) Program

The ADME program was established in July 2000 for Reserve Component Soldiers who incur or aggravate an injury, disease, or illness in the line of duty while on active duty or while performing in an Inactive Duty Training (IDT) status. Public Laws 105-85 and 106-65 of the National Defense Acts of 1998 and 2000, authorize Reserve Component members found by military medical authority to be unable to perform normal military duties in their Military Occupational Skill (MOS) or Area of Concentration (AOC); and if the condition requires treatment that will extend beyond 30-days, to voluntarily submit a written request for placement onto active duty for medical care. The Soldier is placed on

active duty pending the resolution of their medical condition or completion of the Physical Disability Evaluation System (PDES). While on an ADME order, the Soldier and his or her family receive all benefits commensurate with any other Soldier on active duty to include retirement points towards a Reserve retirement. Based on historical flow at the creation of the program, the ADME program was not staffed to accommodate a large numbers of mobilized Reserve Component Soldiers. Beginning in December 2003, the ADME policy and program office started receiving approximately 25 to 30 cases for review daily. At that time, the office staff consisted of three people. Many of the packets arrived incomplete or as the Soldiers' current orders were about to expire or had expired, causing Soldiers to fall off of the pay system and the Defense Enrollment Eligibility Reporting System (DEERS).

The 25-Day Policy

In November 2003, the 25-day rule was instituted to identify mobilizing Soldiers with pre-existing medical conditions. This policy was designed to decrease the number of Soldiers entering the MHO system during the mobilization process and permit mobilizing units to get a replacement for non-deployable Soldiers while remaining within the personnel mobilization cap of the unit.

Within the first 25-days of the mobilization process Soldiers identified with non-deployable medical conditions are now immediately released from active duty. This policy prevents the Army from assuming the responsibility for medical care to Soldiers who have pre-existing medical conditions.

The Medical Retention Processing (MRP) Program

The MRP program was specifically designed for the GWOT contingency operation MHO Soldier and to eliminate the pressure on the

ADME program. It provided a personnel management tool to transition Reserve Component MHO Soldiers from a partial mobilization order to a voluntary retention on active duty order for medical care. This allowed the unit to receive a replacement and not exceed the unit's personnel mobilization cap. As a general rule, a mobilized Reserve Component Soldier remains on partial mobilization orders until a medical authority determines that the Soldier will not be able to perform required duties or that the Soldier will not have a sufficient number of days remaining on active duty after the medical condition improves to permit return to duty. The following guidelines are provided:

1. If the Soldier is expected to return to duty within 60-days from the time he or she is injured or becomes ill and will have at least 120-days left on partial mobilization upon return to duty, then the Soldier will be kept on partial mobilization orders and managed by the installation or unit to which he or she is assigned.

2. If a Soldier is expected to return to duty within 60-days from the time he or she is injured or becomes ill; or if the Soldier could return to duty within 60-days, but has fewer than 120-days beyond the expected return to duty date left on the partial mobilization order and can perform limited duties, then the soldier may consent to conversion from a partial mobilization order to a MRP order. If the Soldier does not consent to be retained on active duty, then he or she will be considered no longer operationally required and will be released from active duty.

3. A Soldier who arrives at the demobilization station who must remain on active duty beyond the period of the partial mobilization order to determine if further medical care or evaluation is warranted may be retained on active duty with his or her consent and the approval of the Commander, Human Resources Command.

4. If treatment through a Community Based Health Care Organization (CBHCO) is approved, the Soldier will convert from his or her

mobilization order to a MRP order with a further attachment to the appropriate CBHCO.

5. A Soldier who is eligible for demobilization who elects not to stay on active duty to receive medical evaluation or treatment, will sign a declination statement and be provided face-to-face counseling and referral for continued medical care while not on active duty.

Human Resources Command (HRC)

The Reserve Components Branch of the Human Resources Command's Personnel Services Support Division supports wounded reserve component Soldiers in two broad areas: manning Medical Retention Processing Units (MRPU) and publishing orders for wounded Soldiers.

The MPRUs, staffed reservists and national guardsmen, provide administrative and command and control. To meet current requirements, HRC has expanded the manning pool to include Soldiers from the Sanctuary program, Extended Active Duty (EAD) and retiree recall programs. This facilitates the wounded Soldier's progress through the system. Reserve Soldiers assigned by HRC also provide much needed liaison to Medical Evaluation Boards that determine Soldier disposition. The other critical mission HRC provides is publishing orders in a timely manner to preclude problems in pay and benefits and ease the Soldier through this complex process. This involves publishing orders moving soldiers from under the authority of Title 10 USC 12302 (Partial Mobilization) to Title 10 USC 12301 (d) (Medical Retention Processing) status. This moves the Soldier from mobilized status to voluntary status and extends their active duty 179 days to preclude "falling off" orders. This also reassigns the Soldier to the installation or garrison Medical Retention Processing Unit (MRPU).

Initiatives to overcome coordination challenges include assuming responsibility for orders as a “one stop shop”. These orders include Active Duty Medical Extension, Medical Retention Processing, Contingency Operation Temporary Tour of Active Duty, Extended Active Duty, Contingency Operation Extended Active Duty and Temporary Tour of Active Duty. Effective, February 15, 2005, HRC Reserve Branch is the responsible agency for all but mobilization orders. This allows both flexibility to meet a Soldier’s needs and visibility of the Soldier throughout this process.

Physical Disability Agency

The following outlines the roles and responsibilities of the G1 and Human Resources Command in the U.S. Army’s Physical Disability Evaluation System (PDES). It comments on lessons learned, challenges, recent initiatives, and offers direction on improving the process, thereby improving the wellbeing of injured Army Guard and Reserve Soldiers and their families. Additionally, it reviews the processing through the Physical Disability Evaluation Systems (PDES) and discusses our direction in improving this process.

We are processing large numbers of disabilities, the likes of which we have not experienced in more than 30 years. In 2004, we processed approximately 15,000 disability cases, nearly a 50% increase from the annual number of cases processed during the years preceding the GWOT. That caseload was distributed across 3 Physical Evaluation Boards (PEBs) in 2 states and the District of Columbia – Ft Lewis, WA, Ft Sam Houston, TX, and at Walter Reed Army Medical Center, and a total of 70 employees. The last time we had that many cases was in 1972, when the PDA processed 19,000 cases. At that time, there were 6 PEBs across 5 states and the District with a total of 260 employees.

We are witnessing an even higher percent increase in the number of mobilized Army Guard and Reservists entering into the disability system, a 134% increase during the last three years. Throughout CY 2004, we applied resources to respond to the wave of new Reserve and National Guard cases. To meet this case load, we increased the staff of the PDA from 60 to 77, a 26% increase; added members to each of the PEBs; increased the number of JAG officers assigned to disability hearings; created a mobile PEB - a 3-member board that travels to each of the fixed PEB sites - to augment their efforts; and placed liaison NCOs at each of the Medical Treatment Facilities and the PDA Headquarters to assist in processing Reserve and National Guard cases. These efforts have paid off. In June 2004, there were 900 Mobilized Reserve and National Guard cases pending in the PDA. Today that number has been reduced to 344. The PDA still receives about 150 new Mobilized Reserve and National Guard cases each month.

For our most seriously injured Soldiers, we created the Disabled Soldier Support System (DS3) that provides the severely disabled Soldiers and their families with a system of advocacy, follow-up and personal support, assisting our heroes as they transition from military service to the civilian community. This program will integrate the many existing programs to provide holistic support services for our severely disabled Soldiers and their families throughout their phased progression from initial casualty notification to their return to home station and final career disposition.

Now I would like to outline the responsibilities of Human Resources Command in the disability process, recognizing that this is a team effort that crosses many command lines. To begin, the Soldier enters the Physical Disability Evaluation System (PDES) when the medical community makes the determination that the Soldier falls below medical retention standards. This requires a Medical Evaluation Board (MEB).

Upon completion of the MEB, the Soldier is referred to one of three Physical Evaluation Boards (PEBs), who will normally adjudicate the case within two days. The Soldier does not appear at this informal board. The informal disposition is conveyed to the Soldier normally by the Physical Evaluation Board Liaison Officer (PEBLO), located at the Medical Treatment Facility, who serves as the Soldier's main point of contact and counselor throughout the disability process. After the PEBLO has presented the disability disposition to the Soldier, he or she can accept the recommended findings or request a formal board with or without personal appearance. At the formal board the Soldier may appear and be represented by legal counsel. Formal boards for mobilized Reserve and National Guard Soldiers are scheduled within thirty days of the Soldier's request. Dispositions can range from the Soldier being found unfit and permanently retired to the Soldier being found fit for duty and returned to duty. Following the completion of an informal and/or formal board, the case is forwarded to the United States Army Physical Disability Agency (USAPDA) for approval and final processing. Once the case has been approved, the USAPDA notifies the command and the transition center of the Soldier's disposition. Once final disability processing is completed, the Soldier is given thirty days to comply with the separation orders. Beginning with the initial portion of the medical board process, the Soldier can submit a request for Continuance in Active Duty Reserve (COAR) in an effort to remain in the military, if determined to be found unfit by the PEB. If the Soldier's request for COAR is approved, then the disability process is terminated at that point. If the Soldier's request for COAR is disapproved by the Soldier's major command (Army National Guard or USAR at HRC St Louis), then the disability process continues as before.

This overview of the disability process only hints at the complexity of what a Soldier goes through when processed through the PDES. As you can see, it is joint effort by multiple commands, who assemble the

required medical information to make a fitness/disability determination; provide sufficient administrative information to process the Soldier for separation or retirement; and provide supportive and caring counseling to the Soldier in order for that Soldier to make a career and, sometimes, life changing decision based on the outcome of the proceedings.

Over the past eighteen months the following actions were taken to improve the processing of the mobilized RC Soldier through the PDES:

1. Stood up the Community Based Health Care Option, presently at five (5) locations and will be eight (8) by April 2005.
2. Established RC LNO positions at the major Medical Treatment Facilities, Regional Medical Commands, power projection platforms and the Defense Finance Accounting Service (DFAS).
3. Revised Army regulations to allow the Mobilization Station Commander to return Soldiers found non-deployable back to the unit, and reduced the out processing time from 90 to 30 days.
4. Established a detailed monitoring network that reports the status of mobilized RC Soldiers in the PDES to the Senior Army Leadership on a biweekly basis.
5. Increased the staff of affected agencies to meet this increased workload, where required.
6. Established the Disabled Soldiers Support System (DS3) to assist the severely injured Soldier and their families, irrespective of component.

While much has been accomplished, more needs to be done. Acting in concert with MEDCOM and the Installation Management Agency, under the direction of ASA(M&RA), the following initiatives are underway:

1. Structuring a comprehensive reporting system that tracks the Soldier as he or she is medically evacuated from the Area of Operation until returned to duty or separated /retirement from the

US Army. A high priority, this task force will present its initial recommendations to the Director of the Army Staff within the next two weeks.

2. As part of the information gathering/sharing enterprise, we are working closely with the Department of Veterans Affairs and the Defense Finance Accounting Services to better coordinate the termination of military pay and the initiation of Veterans Administration Payments. An important linkage to this process is access to the RC Soldiers personnel documents for the calculations of retired and severance pay. Efforts are ongoing to bring automation solutions to this manual process.
3. Through weekly reports, inspections and personal visits, the Army is keeping a close watch on the processing of the Soldiers through the PDES.

Though we have challenges ahead, I am confident we are ensuring that the proper systems are in place and that Soldiers receive the care they deserve.